Today's Date: _____

Patient's Name: _____ Gender: _____

Patient Date of Birth: _____

If Child, Parent's Name: _____

How you wish to be addressed: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Employer: _____

Position: _____

Spouse Name: _____

Spouse Employer: _____

Position: _____

Who is responsible for this account? _____

Purpose of first visit: _____

Other Family Members in this practice: _____

Whom may we thank for this referral: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

CONSENT: I consent to the diagnostic procedures and treatment necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of my records shall be effective until I revoke it in writing. I attest to the accuracy of the information on this page.

Patient or Guardian Signature: _____ **Date:** _____

Our practice is not affiliated with any dental or medical insurance plans as a preferred provider. As a result, we ask for payment at the time services are rendered. We will be happy to assist by providing our patients with information to furnish their insurance companies for potential reimbursement.

Medical Insurance

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____

Dental Insurance

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____

Patient's Name _____Birth date _____ Today's Date _____

Medical problems: ☐ Heart disease ☐ Bleeding disorders ☐ Other_____

☐ Male ☐ Female Birth Weight _____ Present Weight _____ Birth Hospital ☐ _____

☐ Vaginal birth ☐ C-Section Birth Any birth complications? _____

Are you presently breastfeeding ☐ Yes ☐ No If no, how long since you stopped breastfeeding _____

Medical History:

1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? ☐ yes ☐ no
2. Was your infant premature? ☐ Yes ☐ No If yes, how many weeks? _____
3. Does your infant have any heart disease ☐ Yes ☐ No
4. Has your infant had any surgery? ☐ Yes ☐ No

5. Has your infant experienced any of the following? Please check / circle / elaborate as needed.

☐ Shallow latch at breast or bottle
☐ Falls asleep while eating
☐ Slides or pops on and off the nipple
☐ Colic symptoms / Cries a lot
☐ Reflux symptoms
☐ Clicking or smacking noises when eating
☐ Spits up often? Amount / Frequency_____
☐ Gagging, choking, coughing when eating
☐ Gassy (toots a lot) / Fussy often
☐ Poor weight gain
☐ Hiccups often
☐ Lip curls under when nursing or taking bottle

☐ Gumming or chewing your nipple when nursing
☐ Pacifier falls out easily, doesn't like, won't stay in
☐ Milk dribbles out of mouth when nursing/bottle
☐ Short sleeping requiring feedings every 1-2hrs
☐ Snoring, noisy breathing or mouth breathing
☐ Feels like a full time job just to feed baby
☐ Nose congested often
☐ Baby is frustrated at the breast or bottle
How long does baby take to eat? _____
How often does baby eat? _____

6. Is your infant taking any medications? ☐ Reflux ☐ Thrush Name of medication: _____

7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom?

_____

7. Do you have any of the following signs or symptoms? Please check / circle / elaborate as needed.

☐ Creased, flattened or blanched nipples
☐ Lipstick shaped nipples
☐ Blistered or cut nipples
☐ Bleeding nipples
Pain on a scale of 1-10 when first latching _____
Pain (1-10) during nursing: _____

☐ Poor or incomplete breast drainage
☐ Infected nipples or breasts
☐ Plugged ducts / engorgement / mastitis
☐ Nipple thrush
☐ Using a nipple shield
☐ Baby prefers one side over other ____ (R/L)

Pediatrician _____Phone number: _____

Lactation Consultant _____Phone number:_____

Who referred you to us? _____

Doctor's Signature _____